Ultrasound Imaging Concepts

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# ORDER REQUEST FOR ULTRASOUND

Patient Name: _____

Patient Address: _____

Date of Birth: _____ Phone #: _____

Referring Provider: _____

Referring Provider Phone: _____ FAX: _____

☐ Self Pay
☐ Insurance
Primary Insurance: _____
Secondary Insurance: _____
ID: _____ Group: _____
Diagnosis/ ICD 10 Code: _____
Policy Holder: _____ DOB: _____

## EXAMINATION REQUESTED

**Obstetrics/Gynecology**
- ☐ 1St Trimester
- ☐ 2nd Trimester
- ☐ 3rd Trimester
- ☐ Biophysical Profile
- ☐ Pelvis
- ☐ Transvaginal

**Abdomen/Small Part**
- ☐ Abdomen (GB/Liver)
- ☐ Renal
- ☐ Aorta
- ☐ Thyroid
- ☐ Scrotum
- ☐ _____

**Cardiac and Vascular**
- ☐ Diagnostic Echocardiogram
- ☐ Carotid Duplex
- ☐ Venous Duplex (LE)
- ☐ Arterial Duplex (LE)
- ☐ _____

Reason for Exam (symptoms/diagnosis): _____

_____

Previous Ultrasound ☐ Yes ☐ No Date:_____

Special Instructions: _____

_____

Preparation Instructions- **Abdominal Ultrasounds**: Nothing to eat or drink after midnight. **Pelvic Ultrasound**: Full bladder required. Drink 32 oz. of water 45 minutes prior to test.

**Provider's Signature** _____